FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039669

Facility Name: LAKE COOK TERRACE NURSING CENTER, INC.

Address: 263 SKOKIE BOULEVARD (Number) NORTHBROOK (City) 60062 (Zip Code)

County: COOK

Telephone Number: (847) 564-0505 **Fax #** (847) 564-3775

IDPA ID Number: 36-3962479-001

Date of Initial License for Current Owners: 09/28/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) STANTON ARON

(Title) OWNER

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) GARRY CHANKIN, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,940	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,300	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,240	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30		2,422	2,452	8
9	SNF/PED					9
10	ICF	38,984	3,262		42,246	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,014	3,262	2,422	44,698	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.23%

D. How many bed-hold days during this year were paid by Public Aid? 9 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1,039

Medicare Intermediary AdminiStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENT # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	164,044	27,123	14,555	205,722		205,722		205,722			1
2	Food Purchase		209,426		209,426	(23,739)	185,687	(152)	185,535			2
3	Housekeeping	163,395	7,257		170,652		170,652		170,652			3
4	Laundry	72,032	21,172		93,204		93,204		93,204			4
5	Heat and Other Utilities			102,882	102,882		102,882		102,882			5
6	Maintenance	85,258	38,003	72,408	195,669		195,669		195,669			6
7	Other (specify):*											7
8	**TOTAL General Services**	484,729	302,981	189,845	977,555	(23,739)	953,816	(152)	953,664			8
	B. Health Care and Programs											
9	Medical Director			2,575	2,575		2,575		2,575			9
10	Nursing and Medical Records	1,276,666	127,021	9,444	1,413,131		1,413,131	(6,054)	1,407,077			10
10a	Therapy	104,055		11,125	115,180		115,180		115,180			10a
11	Activities	69,010	7,024	2,931	78,965		78,965		78,965			11
12	Social Services	154,207		14,964	169,171		169,171		169,171			12
13	Nurse Aide Training			15,170	15,170		15,170		15,170			13
14	Program Transportation											14
15	Other (specify):*			2,164	2,164		2,164		2,164			15
16	**TOTAL Health Care and Programs**	1,603,938	134,045	58,373	1,796,356		1,796,356	(6,054)	1,790,302			16
	C. General Administration											
17	Administrative	76,144		272,845	348,989		348,989	(124,629)	224,360			17
18	Directors Fees											18
19	Professional Services			62,892	62,892	(80)	62,812	(3,740)	59,072			19
20	Dues, Fees, Subscriptions & Promotions			45,793	45,793		45,793	(14,503)	31,290			20
21	Clerical & General Office Expenses	50,010	60,931	54,527	165,468		165,468	(11,732)	153,736			21
22	Employee Benefits & Payroll Taxes			357,936	357,936	23,739	381,675	(7,644)	374,031			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,483	3,483		3,483	(369)	3,114			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			42,092	42,092		42,092		42,092			26
27	Other (specify):*							6,701	6,701			27
28	**TOTAL General Administration**	126,154	60,931	839,568	1,026,653	23,659	1,050,312	(155,916)	894,396			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,214,821	497,957	1,087,786	3,800,564	(80)	3,800,484	(162,122)	3,638,362			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

LAKE COOK TERRACE NURSING CENTER, INC.
0039669
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	23,739	
2	FOOD		23,739

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	80	
19	PROFESSIONAL FEES		80

To reclass cost of appealing real estate taxes

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. #0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			52,638	52,638		52,638	97,159	149,797			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,815	17,815		17,815	134,455	152,270			32
33	Real Estate Taxes			146,485	146,485	80	146,565		146,565			33
34	Rent-Facility & Grounds			562,100	562,100		562,100	(562,100)				34
35	Rent-Equipment & Vehicles			24,910	24,910		24,910		24,910			35
36	Other (specify):*											36
37	**TOTAL Ownership**			803,948	803,948	80	804,028	(330,486)	473,542			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		29,742	45,113	74,855		74,855		74,855			39
40	Barber and Beauty Shops			93	93		93		93			40
41	Coffee and Gift Shops			923	923		923	(923)				41
42	Provider Participation Fee			76,860	76,860		76,860		76,860			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		29,742	122,989	152,731		152,731	(923)	151,808			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,214,821	527,699	2,014,723	4,757,243		4,757,243	(493,531)	4,263,712			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	28,074	30		9
10	Interest and Other Investment Income	(69)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(152)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,666)	20		20
21	Owner or Key-Man Insurance	(7,644)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,408)	21		24
25	Fund Raising, Advertising and Promotional	(9,206)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(324)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,631)	20		28
29	Other-Attach Schedule	(15,963)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (21,989)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(471,542)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (471,542)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (493,531)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

LAKE COOK TERRACE NURSING CENTER, INC.

ID# 0039669

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	GAF PARTNERSHIP TRUST FEES	(50)	20	2
3	RESIDENT CLOTHING	(128)	10	3
4	VA EXPENSE	(5,926)	10	4
5	GAF PARTNERSHIP SRT	(4,827)	21	5
6	VENDING INCOME	(923)	41	6
7	PRIOR YEAR SEMINAR	(369)	24	7
8	PRIOR YEAR LEGAL BILLS	(3,740)	19	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(15,963)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(152)											(152)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance													6
7	Other (specify):*													7
8	**TOTAL General Services**	(152)											(152)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(6,054)											(6,054)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(6,054)											(6,054)	16
	C. General Administration													
17	Administrative			(77,472)	(19,157)	(28,000)							(124,629)	17
18	Directors Fees													18
19	Professional Services	(3,740)											(3,740)	19
20	Fees, Subscriptions & Promotions	(14,553)	50										(14,503)	20
21	Clerical & General Office Expenses	(16,559)	4,827										(11,732)	21
22	Employee Benefits & Payroll Taxes	(7,644)											(7,644)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(369)											(369)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			3,286		3,415							6,701	27
28	**TOTAL General Administration**	(42,865)	4,877	(74,186)	(19,157)	(24,585)							(155,916)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(49,071)	4,877	(74,186)	(19,157)	(24,585)							(162,122)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	28,074	69,085										97,159	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(69)	134,524										134,455	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(562,100)										(562,100)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	28,005	(358,491)										(330,486)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(923)											(923)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(923)											(923)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(21,989)	(353,614)	(74,186)	(19,157)	(24,585)							(493,531)	45

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				GAF PARTNERSHIP		Bldg. Partnership

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	RENT	$ 562,100	GAF PARTNERSHIP	100.00%	$	$ (562,100)	1
2	V									2
3	V		32	MORTGAGE INTEREST		GAF PARTNERSHIP	100.00%	150,154	150,154	3
4	V		21	STATE REPLACEMENT TAX		GAF PARTNERSHIP	100.00%	4,827	4,827	4
5	V		30	DEPRECIATION		GAF PARTNERSHIP	100.00%	69,085	69,085	5
6	V		20	TRUST FEES		GAF PARTNERSHIP	100.00%	50	50	6
7	V		32	INTEREST INCOME	15,630	GAF PARTNERSHIP	100.00%		(15,630)	7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 577,730			$ 224,116	$ * (353,614)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - STAN ARON	$	PRO HEALTH CARE, INC.	100.00%	$ 76,216	$ 76,216	15
16	V	27	PAYROLL TAXES		PRO HEALTH CARE, INC.		3,286	3,286	16
17	V	0					0		17
18	V	0					0		18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	17	MNGMNT. FEES - GAF, LTD.	100,000	PRO HEALTH CARE, INC.	100.00%	0	(100,000)	23
24	V	17	MNGMNT. FEES - PRO HEALTH	53,688	PRO HEALTH CARE, INC.	100.00%	0	(53,688)	24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 153,688			$ 79,502	$ * (74,186)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	0		$	GAF, LTD.	100.00%	$ 0	$	15
16	V	17	MANAGEMENT FEES	219,157			0	(219,157)	16
17	V	17	MNGMNT. FEES - FINN CONS.				100,000	100,000	17
18	V	17	MNGMNT. FEES - PRO HEALTH				100,000	100,000	18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 219,157			$ 200,000	$ * (19,157)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - J. FINN	$	FINN CONSULTING, INC.	100.00%	$ 72,000	$ 72,000	15
16	V	27	PAYROLL TAXES				3,415	3,415	16
17	V	0					0		17
18	V	17	MANAGEMENT FEES	100,000			0	(100,000)	18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 100,000			$ 75,415	$ * (24,585)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE COOK TERRACE NURSING CEN # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STANTON ARON	OWNER	ADMIN.	12.95	SEE ATTACHED	23	35.38	ALLOC. PRO	$ 76,216	17-7	1
2	JACK FINN	OWNER	ADMIN.	17.26	SEE ATTACHED	18	51.42	ALLOC. FINN	72,000	17-7	2
3	NANJEAN PAINTER	OWNER	ADMIN.	1.44	SEE ATTACHED	10	20.00	DIETARY	7,008	01-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 155,224		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PRO HEALTH CARE, INC. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60115
Phone Number: (847)236-1111
Fax Number: (847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - STAN ARON	AVG. HOURS WORKED	51	4	$ 169,000	$ 169,000	23	$ 76,216	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED	51	4	7,285		23	3,286	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 176,285	$ 169,000		$ 79,502	25

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: GAF, LTD. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60115
Phone Number: ((847)236-1111
Fax Number: ((847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3	17	MNGMNT. FEES - FINN CONS.	DIRECT ALLOCATION	1	1	100,000			100,000	3
4	17	MNGMNT. FEES - PRO HEALT	DIRECT ALLOCATION	1	1	100,000			100,000	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 200,000	$		$ 200,000	25

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FINN CONSULTING INC.
Street Address: 2901 W. COYLE
City / State / Zip Code: CHICAGO, IL 60645
Phone Number: ((773)764-3466
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - J. FINN	AVG. HOURS WORKED	35	2	$ 140,000	$ 140,000	18	72,000	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED	35	2	6,641		18	3,415	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 146,641	$ 140,000		$ 75,415	25

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number LAKE COOK TERRACE NURSING CENT # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MANUFACTURES BANK		X	LINE OF CREDIT		7/10/00	120,000	330,000	7/10/01	9.5000	17,815	6
7												7
8												8
9	TOTAL Facility Related						$ 120,000	$ 330,000			$ 17,815	9
	B. Non-Facility Related*											
10	Supplemental Schedule							1,748,635			134,455	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 1,748,635			$ 134,455	14
15	TOTALS (line 9+line14)						$ 120,000	$ 2,078,635			$ 152,270	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME		X				$	$			$ (69)	1
2	ALLOCATED GAF PARTNERS	X		INTEREST INCOME							(15,630)	2
3	ALLOCATED GAF PARTNERS	X		MORTGAGE	40,401.00	9/93	2,265,836	1,608,635		10.75%	150,154	3
4	DUE TO SHERIDAN							140,000				4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$ 2,265,836	$ 1,748,635			$ 134,455	21

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	146,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	143,084	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,716)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	150,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	80	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 240 For 19 93 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	146,564	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	134,940	8
	1996	135,555	9
	1997	136,449	10
	1998	139,820	11
	1999	143,084	12

REAL ESTATE TAX ACCRUAL = $143,084*1.04=150,200

REAL ESTATE TAX REFUND NOT OFFSET SINCE THE REFUND RELATED TO A TAX BILL NOT USED FOR REIMBURSEMENT.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame BRICK Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY			$ 200,000	1
2					2
3	TOTALS			$ 200,000	3

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	140		1993		$ 2,132,500	$ 54,679	35	$ 51,946	$ (2,733)	$ 507,150	4
5			1993		25,000			1,250	1,250	6,250	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1994	61,594	1,695	20	3,079	1,384	19,228	9
10	Various			1995	220,229	5,461	20	11,014	5,553	60,947	10
11	GLASS			1996	2,750	71	20	138	67	621	11
12	DINING ROOM PANELING			1996	4,973	128	20	249	121	1,224	12
13	WALLPAPER			1996	1,504	39	20	75	36	375	13
14	PLUMBING			1996	2,695	69	20	135	66	652	14
15	SPRINKLER			1996	3,480	89	20	174	85	841	15
16	PIPING			1996	1,880	48	20	94	46	439	16
17	BOILERS			1996	12,485	320	20	624	304	3,120	17
18	PUMP SERVICE			1996	5,600	144	20	280	136	1,307	18
19	BLOCK WALL TERRACE			1996	11,000	282	20	550	268	2,658	19
20	WINDOWS			1996	5,500	141	20	275	134	1,306	20
21	CONCRETE			1996	330		20	17	17	34	21
22	CHANDELIER			1996	462	12	20	23	11	115	22
23	ILLUMINATED SIGN			1996	9,528	244	20	476	232	2,221	23
24											24
25	PAGE 12-1 REP TOTALS				584,042	12,385		26,326	13,941	257,812	25
26											26
27											27
28											28
29											29
30											30
31	PAGE 12E TOTALS				44,186	403		802	399	802	31
32	PAGE 12D TOTALS				224,284	3,585		7,434	3,849	7,930	32
33	PAGE 12C TOTALS				90,742	2,176		4,536	2,360	8,215	33
34	PAGE 12B TOTALS				94,816	2,432		4,742	2,310	15,693	34
35	PAGE 12A TOTALS				135,571	3,852		6,779	2,927	28,474	35
36	TOTAL (lines 4 thru 35)				$ 3,675,151	$ 88,255		$ 121,018	$ 32,763	$ 927,414	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LAUNDRY ROOM			1996	1,250	32	20	63	31	284	9
10	SIGNS			1996	2,902	74	20	145	71	677	10
11	FIRE DOOR			1996	4,845	124	20	242	118	988	11
12	MASONRY			1996	16,440	422	20	822	400	3,562	12
13	MASONRY			1996	1,785	46	20	89	43	438	13
14	AIR CONDITIONERS			1996	5,250	135	20	263	128	1,074	14
15	CONCRETE			1996	18,650	478	20	933	455	4,509	15
16	SIGNALING DEVICE			1996	642		20	32	32	64	16
17	PANELS			1996	1,007	116	20	50	(66)	242	17
18	PANELS			1996	1,143	131	20	57	(74)	280	18
19	CONCRETE			1996	330		20	17	17	34	19
20	ELECTRIC			1996	2,985	77	20	149	72	671	20
21	PUMP			1996	3,968	102	20	198	96	907	21
22	FENCE			1996	1,400	36	20	70	34	321	22
23	MONITOR			1996	1,030	26	20	52	26	260	23
24	FLOOR TILE			1996	7,169	184	20	358	174	1,790	24
25	LAUNDRY ROOM			1996	1,875	48	20	94	46	431	25
26	MASONRY			1996	6,820	175	20	341	166	1,421	26
27	ELECTRICAL			1997	13,000	333	20	650	317	2,438	27
28	ROOF			1997	18,500	474	20	925	451	3,392	28
29	DOOR INSTALLATION			1997	1,445	37	20	72	35	288	29
30	PIPING			1997	1,690	43	20	85	42	340	30
31	DOOR INSTALLATION			1997	3,400	87	20	170	83	680	31
32	PIPING			1997	7,585	194	20	379	185	1,421	32
33	OUTDOOR IMPROVEMENTS			1997	3,700	285	20	185	(100)	694	33
34	CEILING			1997	6,760	173	20	338	165	1,268	34
35	PIPING			1997		20	20		(20)		35
36	TOTAL (lines 4 thru 35)				$ 135,571	$ 3,852		$ 6,779	$ 2,927	$ 28,474	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LAKESIDE GLASS			1997	650	17	20	33	16	132	9
10	PANELING			1997	1,263	32	20	63	31	221	10
11	SHOWER ROOM			1997	925	24	20	46	22	176	11
12	PIPING			1997	775	20	20	39	19	146	12
13	REMODELING			1997	5,727	147	20	286	139	1,001	13
14	SECURITY UNIT			1997	873	22	20	44	22	158	14
15	DOORS			1997	1,125	29	20	56	27	210	15
16	PIPING			1997	4,575	117	20	229	112	916	16
17	REMODELING			1997	2,428	62	20	121	59	373	17
18	DOORS			1997	1,115	29	20	56	27	201	18
19	SECURITY UNIT			1997	1,691	43	20	85	42	305	19
20	REMODELING			1997	12,372	317	20	619	302	2,218	20
21	DOORS			1997	1,842	47	20	92	45	299	21
22	CONCRETE FLOOR			1997	9,443	242	20	472	230	1,691	22
23	VALVE			1997	1,000	26	20	50	24	183	23
24	STORAGE TANKS			1997	11,590	297	20	580	283	2,223	24
25	HEATING SYSTEM			1997	4,006	103	20	200	97	717	25
26	DRYWALL & ALUM RETAI			1998	1,528	39	20	76	37	171	26
27	DUCT WORK			1998	1,170	30	20	59	29	157	27
28	PLUMBING			1998	1,663	43	20	83	40	194	28
29	GREASE TRAP-PLUMBING			1998	1,190	31	20	60	29	175	29
30	PATIO			1998	1,230	32	20	62	30	160	30
31	CIRCUITRY			1998	635	16	20	32	16	93	31
32	ROOFING & INSULATION			1998	19,800	508	20	990	482	2,723	32
33	HOT WATER HEATER			1998	4,246	109	20	212	103	583	33
34	SECURITY DEVICE			1998	669	17	20	33	16	91	34
35	WALK IN COOLER			1998	1,285	33	20	64	31	176	35
36	TOTAL (lines 4 thru 35)				$ 94,816	$ 2,432		$ 4,742	$ 2,310	$ 15,693	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PUMP MOTOR			1998	518	13	20	26	13	67	9
10	CARPETING			1998	816	21	20	41	20	109	10
11	DRAPERIE			1998	5,309		20	265	265	685	11
12	PLUMBING & TOILETS			1998	3,408	87	20	170	83	383	12
13	EXHAUST PIPING			1998	5,400	138	20	270	132	698	13
14	FLOOR & WALL TILES			1998	2,325	60	20	116	56	251	14
15	WALLPAPER & TILING			1998	5,633	144	20	282	138	588	15
16	EJECTOR PUMPS			1998	1,675	43	20	84	41	175	16
17	TILES			1998	2,038	52	20	102	50	221	17
18	CARPETING			1998	889	23	20	44	21	99	18
19	ROOM REMODELING			1999	3,480	89	20	174	85	319	19
20	BATH WALLS & FLOORS			1999	12,886	330	20	644	314	1,127	20
21	SINK			1999	1,618	41	20	81	40	149	21
22	ELECTRICAL			1999	965	25	20	48	23	80	22
23	DOORS			1999	718	18	20	36	18	63	23
24	WALLPAPER & TILING			1999	8,242	211	20	412	201	687	24
25	FAUCET			1999	986	25	20	49	24	90	25
26	BOILER			1999	2,985	77	20	149	72	286	26
27	ROOM REMODELING			1999	4,354	112	20	218	106	345	27
28	WOOD DOORS			1999	3,891	100	20	195	95	358	28
29	ROOM REMODELING			1999	2,207	57	20	110	53	156	29
30	DOORS			1999	446	11	20	22	11	37	30
31	ROOM REMODELING			1999	2,250	58	20	113	55	188	31
32	PANELING			1999	785	20	20	39	19	52	32
33	TOILETS			1999	3,156	81	20	158	77	290	33
34	WALLPAPER & CARPETIN			1999	12,296	302	20	615	313	615	34
35	VANITY			1999	1,466	38	20	73	35	97	35
36	TOTAL (lines 4 thru 35)				$ 90,742	$ 2,176		$ 4,536	$ 2,360	$ 8,215	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALL BATH BARS			1999	519	13	20	26	13	48	9
10	WALLPAPER			1999	1,126	29	20	56	27	84	10
11	BATHROOM HARDWARE			1999	460	12	20	23	11	29	11
12	WALL TILE			1999	930	24	20	47	23	94	12
13	CORNICES & PANELING			1999	3,882	100	20	194	94	388	13
14	ROOM REMODELING			1999	5,137	132	20	257	125	278	14
15	LIGHT FIXTURES			1999	2,476	63	20	124	61	186	15
16	ARCHITECT			1999	4,060	100	20	203	103	203	16
17	ARCHITECT			1999	8,000	196	20	400	204	400	17
18	LANDSCAPING			1999	1,327	133	20	88	(45)	88	18
19	CORNICES			1999	6,954	178	20	348	170	464	19
20	REDECORATING			2000	26,956	374	20	874	500	874	20
21	WASH SINK			2000	516	6	20	26	20	26	21
22	PUMP			2000	1,409		20	65	65	65	22
23	W. GLASS			2000	650		20	30	30	30	23
24	WINDOW			2000	772	11	20	23	12	23	24
25	PAINTING			2000	1,500	21	20	44	23	44	25
26	EXTERIOR LIGHTING			2000	2,569	41	20	86	45	86	26
27	OFFICE EXPANSON			2000	129,746	1,802	20	3,784	1,982	3,784	27
28	GLASS			2000	4,000	47	20	100	53	100	28
29	WALLPAPER			2000	846	12	20	25	13	25	29
30	WALLPAPER			2000	6,640	135	20	277	142	277	30
31	SOUND SYSTEM			2000	783	14	20	29	15	29	31
32	THERMOPANE WINDOWS			2000	6,244	87	20	182	95	182	32
33	VENTING			2000	1,940	6	20	16	10	16	33
34	CURIO CABINET			2000	2,725	20	20	45	25	45	34
35	WA MONITOR			2000	2,117	29	20	62	33	62	35
36	TOTAL (lines 4 thru 35)				$ 224,284	$ 3,585		$ 7,434	$ 3,849	$ 7,930	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	TILES			2000	5,447	53	20	113	60	113	9
10	ELECTRIC			2000	800	4	20	10	6	10	10
11	WA MONITORS			2000	1,030	14	20	30	16	30	11
12	LANDSCAPING			2000	1,065	54	20	31	(23)	31	12
13	WASHROOM REMODELING			2000	7,800	75	20	163	88	163	13
14	ROOFING			2000	1,190	9	20	20	11	20	14
15	REFRIGERATOR			2000	2,288	32	20	67	35	67	15
16	BOILER			2000	660	9	20	19	10	19	16
17	DECORATING			2000	855	10	20	21	11	21	17
18	TOILET			2000	2,130	16	20	36	20	36	18
19	FIRE ALARM			2000	8,781	28	20	73	45	73	19
20	DOOR RELEASE BUTTON			2000	728	10	20	21	11	21	20
21	HEAT EXCHANGER			2000	1,745	9	20	22	13	22	21
22	WINDOW TREATMENT			2000	5,068	16	20	42	26	42	22
23	WINDOWS AND DOORS			2000	4,599	64	20	134	70	134	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 44,186	$ 403		$ 802	$ 399	$ 802	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	GAF PARTNERSHIP			1981	5,694		20			5,694	9
10	GAF PARTNERSHIP			1982	17,924		20			17,924	10
11	GAF PARTNERSHIP			1983	5,201		20			5,201	11
12	GAF PARTNERSHIP			1984	27,884		20			27,884	12
13	GAF PARTNERSHIP			1985	77,350	2,232	20	3,870	1,638	43,972	13
14	GAF PARTNERSHIP			1986	37,603	1,579	20	1,880	301	30,646	14
15	GAF PARTNERSHIP			1987	38,247	1,213	20	1,913	700	17,612	15
16	GAF PARTNERSHIP			1988	13,918	441	20	650	209	6,576	16
17	GAF PARTNERSHIP			1989	53,326	1,559	20	2,667	1,108	21,325	17
18	GAF PARTNERSHIP			1990	39,155	1,244	20	1,958	714	14,714	18
19	GAF PARTNERSHIP			1991	101,697	1,552	20	5,085	3,533	30,310	19
20	GAF PARTNERSHIP			1992	16,406	307	20	821	514	3,695	20
21	GAF PARTNERSHIP			1993	149,637	2,258	20	7,482	5,224	32,259	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 584,042	$ 12,385		$ 26,326	$ 13,941	$ 257,812	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 518,939	$ 25,157	$ 25,218	$ 61		$ 352,305	37
38	Current Year Purchases	37,517	7,505	2,861	(4,644)		2,861	38
39	Fully Depreciated Assets	122,795					122,795	39
40								40
41	TOTALS	$ 679,251	$ 32,662	$ 28,079	$ (4,583)		$ 477,961	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY VAN	USED VAN	1997	$ 6,999	$ 806	$ 700	$ (106)	10	$ 2,333	42
43										43
44										44
45										45
46	TOTALS			$ 6,999	$ 806	$ 700	$ (106)		$ 2,333	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,561,401	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 121,723	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 149,797	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 28,074	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,407,708	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

LAKE COOK TERRACE NURSING CENTER, INC.
0039669
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
GAF LAKE COOK, INC	229,290	23,136	22,953	(183)	86,947
GAF LAKE COOK TERRACE	289,649	2,021	2,265	244	265,358
TOTALS	518,939	25,157	25,218	61	352,305

LINE 29: CURRENT YEAR

GAF LAKE COOK, INC	37,517	7,505	2,861	(4,644)	2,861
GAF LAKE COOK TERRACE					
TOTALS	37,517	7,505	2,861	(4,644)	2,861

LINE 30: FULLY DEPRECIATED

GAF LAKE COOK, INC					
GAF LAKE COOK TERRACE	122,795				122,795
TOTALS	122,795				122,795

TOTALS (Should Tie to Totals on Page 13)

GAF LAKE COOK, INC	266,807	30,641	25,814	(4,827)	89,808
GAF LAKE COOK TERRACE	412,444	2,021	2,265	244	388,153
TOTALS	679,251	32,662	28,079	(4,583)	477,961

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 17,122 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	1998 ACURA	$ 649.00	$ 7,788	17
18					18
19					19
20					20
21	TOTAL		$ 649.00	$ 7,788	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$ 10,619	$ 4,551	$	$ 15,170
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 10,619	$ 4,551	$	$ 15,170
10	SUM OF line 9, col. 1 and 2 (e)	$ 15,170			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	14
2. From other facilities (f)	
TOTAL TRAINED	20

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-2;39-3	hrs	$		$ 7,809	$ 2,295		$ 10,104	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			750			750	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			36,554			36,554	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				17,141		17,141	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**						10,306		10,306	13
14	TOTAL			$		$ 45,113	$ 29,742		$ 74,855	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	4,272
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5	LAB AND X RAY	1,053
6	IV CARE	4,981
7		
8		
9		
10		
		10,306

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 94,383	$ 367,407	1
2	Cash-Patient Deposits	36,918	36,918	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,054,148	1,054,148	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,923	30,923	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	51,510	51,510	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,267,882	$ 1,540,906	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,000	2,000	12
13	Land		200,000	13
14	Buildings, at Historical Cost		2,132,500	14
15	Leasehold Improvements, at Historical Cos	876,777	1,284,353	15
16	Equipment, at Historical Cost	289,738	701,251	16
17	Accumulated Depreciation (book methods)	(309,669)	(1,332,563)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 858,846	$ 2,987,541	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,126,728	$ 4,528,447	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 200,781	$ 200,781	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	48,402	48,402	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,088	95,088	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,242	7,242	31
32	Accrued Real Estate Taxes(Sch.IX-B)	150,200	150,200	32
33	Accrued Interest Payable		11,777	33
34	Deferred Compensation			34
35	Federal and State Income Taxes		4,827	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	1,418	1,418	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 503,131	$ 519,735	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,049,849	470,000	39
40	Mortgage Payable		1,608,635	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,049,849	$ 2,078,635	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,552,980	$ 2,598,370	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 573,748	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,126,728	$ #REF!	48

*(See instructions.)

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	51,510	51,510
	51,510	51,510

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses	1,418	1,418
Accrued R. E. Tax - Non Care Property		
	1,418	1,418

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit		
Loan Costs		

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 372,342	1
2	Restatements (describe):		2
3	**Schedule attached**	6	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 372,348	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	201,400	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 201,400	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 573,748	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	LAKE COOK TERRACE NURSING C#	0039669	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		372,348
Adjustments:		
		-
		-
		-
ROUNDING		(6)
Total adjustments		(6)
Balance - Beginning of Year		372,342
Equity(Deficit) from Page 17 Col 1		573,748
Related Party		
Equity(Deficit)	1002715	
Income	353614	
		1,356,329
Combined Equity - End of Year		1,930,077

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, I # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,880,145	1
2	Discounts and Allowances for all Levels	(78,678)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,801,467	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	87,081	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 87,081	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	36,174	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,864	19
20	Radiology and X-Ray	2,222	20
21	Other Medical Services	19,525	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 66,785	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	69	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 69	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	3,241	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,241	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,958,643	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	977,555	31
32	Health Care	1,796,356	32
33	General Administration	1,026,653	33
	B. Capital Expense		
34	Ownership	803,948	34
	C. Ancillary Expense		
35	Special Cost Centers	75,871	35
36	Provider Participation Fee	76,860	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,757,243	40
41	**Income before Income Taxes (line 30 minus line 40)****	201,400	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 201,400	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LAKE COOK TERRACE NURSINC # 0039669 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2	UNIFORMS	1,411
3	VENDING REVENUE (EXPENSE IS ADJUSTED OUT ON P.5)	1,590
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	3,001

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 61,132	$ 29.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,811	11,337	243,616	21.49	3
4	Licensed Practical Nurses	18,351	19,727	382,787	19.40	4
5	Nurse Aides & Orderlies	68,987	71,986	570,808	7.93	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,072	10,472	104,055	9.94	8
9	Activity Director					9
10	Activity Assistants	6,657	6,973	69,010	9.90	10
11	Social Service Workers	12,021	12,752	154,207	12.09	11
12	Dietician					12
13	Food Service Supervisor	1,348	1,524	36,209	23.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,583	18,095	127,835	7.06	15
16	Dishwashers					16
17	Maintenance Workers	7,587	7,759	85,258	10.99	17
18	Housekeepers	20,759	21,935	163,395	7.45	18
19	Laundry	7,889	8,269	72,032	8.71	19
20	Administrator	2,080	2,080	76,144	36.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,104	3,192	50,010	15.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,125	1,161	18,323	15.78	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	190,454	199,342	$ 2,214,821 *	$ 11.11	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	370	$ 14,555	01-3	35
36	Medical Director	80	2,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	85	2,379	10-3	38
39	Pharmacist Consultant	117	5,110	10-3	39
40	Physical Therapy Consultant	140	7,012	10a-3	40
41	Occupational Therapy Consultant	76	3,788	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	325	10a-3	43
44	Activity Consultant	45	2,931	11-3	44
45	Social Service Consultant	186	7,432	12-3	45
46	Other(specify) DENTAL	29	2,164	15-3	46
47	PSYCHO-SOCIAL	250	7,532	12-3	47
48	OPTOMETRIST	4	175	09-3	48
49	TOTAL (lines 35 - 48)	1,389	$ 55,803		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	76	1,955	10-3	52
53	TOTAL (lines 50 - 52)	76	$ 1,955		53

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, I # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHELLY MARTINEZ	ADMINISTRATOR	0	$ 76,144
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,144

B. Administrative - Other

Description	Amount
PRO HEALTH ADMIN FEES	$ 53,688
GAF LTD. MGMNT FEES	219,157
TOTAL (agree to Schedule V, line 17, col. 3)	$ 272,845
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
MECKLER, BULGER, TILSON	LEGAL	$ 1,010
FRANK RUFFNER MONT.	LEGAL	494
WEINTRAUB	LEGAL	5,725
KATZ, RANDALL, WEINBERG	LEGAL	80
LANER MUCHIN	LEGAL	1,636
FROST,RUTTENBERG, ROTH	ACCOUNTING	42,593
BREAKPOINT TECHNOLOGY	COMPUTERS	682
PERSONNEL PLANNERS	UNEMPLOYMENT	1,300
HEALTHREV, INC	BILLING	6,125
STAFF FINDERS	RECRUITMENT	639
BISYS	401K CONSULTANT	2,600
PAYCHEX	COMPUTERS	8
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 62,892

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,116
Unemployment Compensation Insurance	20,539
FICA Taxes	168,731
Employee Health Insurance	89,569
Employee Meals	23,739
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE HOSPITAL BILLS	9,479
MISC. EMPLOYEE BENEFITS	570
HOLIDAY EXPENSE	2,288
TOTAL (agree to Schedule V, line 22, col.8)	$ 374,031

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	13,971
Health Care Worker Background Check	1,000
(Indicate # of checks performed 83)	
LICENSES AND FEES	8,277
IL COUNCIL ON LTC	7,640
DUES	243
ADVERTISING	1,631
Less: Public Relations Expense	(241)
Non-allowable advertising	( )
Yellow page advertising	(1,631)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,290

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,114
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,114

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LAKE COOK TERRACE NURSING CENTER, INC. # 0039669 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LTC $7,640**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,124** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **76,860**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **23,739** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%:L14**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw